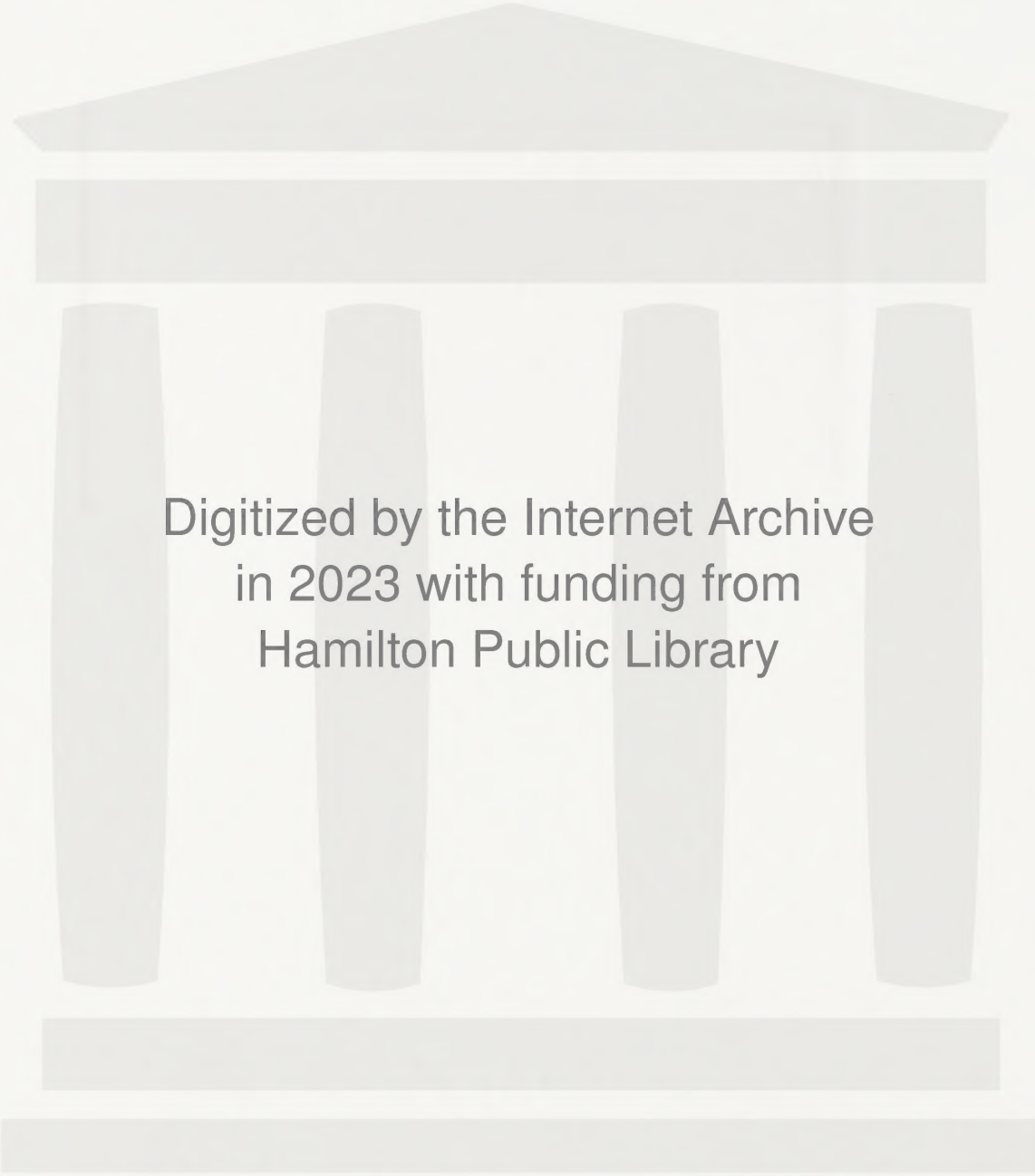


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OUR HEALTH, OUR FUTURE : A
COMPREHENSIVE HEALTH CARE
PLAN FOR HAMILTON-WENTWORTH:
HEALTH ACTION TASK FORCE
WORKING PAPER ON PRIMARY CARE



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OUR HEALTH, OUR FUTURE

A COMPREHENSIVE HEALTH CARE PLAN FOR HAMILTON-WENTWORTH

HEALTH ACTION TASK FORCE WORKING PAPER ON PRIMARY CARE

prepared by the
Primary Health Care Working Group
February 23 , 1996

Hamilton-Wentworth District Health Council

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Preface

The Health Action Task Force was mandated by the District Health Council in February 1995 to develop a comprehensive health care plan to guide the restructuring and management of health care services in Hamilton-Wentworth.

Working papers and supporting documents were developed by working groups, and in some instances, staff and consultants. These documents focused on acute care, emergency and land ambulance services, primary health care, continuing care, inclusive of long term care, chronic care rehabilitation and chronic care, mental health, a H-W community profile, health human resource planning, facilities assessments, health system integration, and results from open consultations.

Working group membership generally included Task Force members, District Health Council members, planning staff and Ministry of Health resource persons. Each working group was chaired by a member of the Health Action Task Force. The purpose of the working groups was to define the scope of the task, and determine the consultation processes required to inform the task. Working groups, and staff, were responsible for identifying relevant data and information, key stakeholders, key informants, relevant literature, and studies and reports. The reports of the working groups and staff reports were received as information by the Task Force.

All of the working groups were working concurrently. Some recommendations were made in the absence of evolving information, new analyses and facilities assessments. All recommendations were considered by the Task Force in the development of a comprehensive and cohesive health care plan.

For additional information, please contact the District Health Council at 570-0354 Ext. 159.



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PRIMARY CARE REPORT OF THE HEALTH ACTION TASK FORCE

HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL

March 29, 1996

ERRATA

Morbidity Rates

Table 2, p. 8, the Hamilton-Wentworth SMR is 0.21 for Depression.

Table 2, p. 9, the Hamilton-Wentworth SMR is 0.96 for Complications of Pregnancy

Primary Health Care Working Group

Membership

Nancy Di Gregorio,	Chairperson, Primary Health Care Working Group Health Action Task Force
Olga Roman,	Health Action Task Force
Sharon Cavanagh,	Hamilton-Wentworth District Health Council
Philomena Newberry,	Hamilton-Wentworth District Health Council
Mary Lou Gignac,	Senior Policy Advisor, Health Strategies Office, Ministry of Health

Planning Staff:

Susan Goodman
Basilia Iatomasi
Barry Hallman

Support Staff:

Betty McConnell

1.0 BACKGROUND

1.1 Introduction

Primary health care, like the entire health care system, is being debated and is under scrutiny in many arenas today. Provincially and nationally the following groups have, or are examining primary health care:

- five chairs of Family Medicine in Ontario
- Ontario College of Family Physicians
- College of Family Physicians of Canada
- Ontario Medical Association's Primary Care Reform Group
- Federal/Provincial/Territorial Advisory Committee on Health Services
- Primary Health Care Sub-committee of the
Provincial Coordinating Committee on Community and
Academic Health Sciences Relations
- Primary Health Care Delivery Models Working Group
of the Community Health Framework Project

Although this report focuses specifically on the local primary health care context, it is recognized that some local issues are mirrored provincially and nationally. It is also recognized that future provincial reforms will have a profound impact on the local delivery and funding of primary health care.

This report supports the view that primary health care is the cornerstone of the health care system. Primary health care professionals respond to the various and changing needs of individuals and populations by providing comprehensive care. They play key roles in preventing or reducing the burden of illness and in providing curative and rehabilitative care when required.

To function optimally, the primary health care system must be consumer focused. It must be characterized by integrated, coordinated, accessible and universal services which seamlessly and appropriately connect to secondary and tertiary care. Family physicians have a central role in ensuring that consumers receive the appropriate medical services, by the appropriate health providers at the appropriate time. In addition, collaborative, interdisciplinary relationships between family physicians and a range of primary health care providers are necessary to ensure that comprehensive and coordinated services are provided. Lastly, primary health care professionals must have the tools and resources, such as education, teaching, research and information, to effectively fulfill their roles.

1.2 Definitions

This report uses the World Health Organization (WHO) definition of primary health care

“Primary health care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost the community and country can afford. . . . It forms an integral part of the country’s health care system of which it is the nucleus It is the first level of contact of individuals, the family and the community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process Primary health care addresses the main problems in the community, by providing promotive, preventative, curative, supportive and rehabilitative resources accordingly.”¹

It should be noted that primary medical care is one component of primary health care. The Canadian Medical Association defines primary medical care as first contact care which includes the diagnosis, treatment and management of health problems using preventive and promotive strategies at the individual, family and community level.²

Both definitions emphasize that care is continuous, coordinated and comprehensive.

The focus of this report is on primary health care. There are references however, to primary medical care which for the purposes of this report refers to the services provided by general practitioners and family physicians.

References are also made to health promotion. The Ottawa Charter definition is used:

“Health promotion is the process of enabling individuals and communities to increase control over the factors which protect their health, thereby improving their health. The factors which determine the health of individuals and their communities are both individual and societal, including the social, environmental and economic structures of our communities. Individuals need peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity as a prerequisite to health.”³

1.3 Methodology

Several methods were used to gather information for this report. Local research reports and various position papers on primary health care were reviewed. In order to obtain input from health providers, several key informant interviews were conducted throughout the consultation process. Five focus groups were also held with primary health care professionals, which included nurses, physicians, dieticians, optometrists, social workers, midwives, physiotherapists, pharmacists and chiropodists. Input was also received as a result of presentations made by the Primary Health Care Working Group to specific committees involved in primary health care. Numerous written briefs and letters from primary health care professionals to the Primary Health Working Group were also considered.

Input from consumers for this and other working group reports was derived from 1-800 calls, comments written on the tear off portion of a newspaper supplement, eight open houses and through written briefs and letters.

1.4 Limitations

As with any process there were limitations. The short time frame did not permit as extensive or thorough a consultation process as would have been normally desired. There are also limitations in the data that were available to describe the local primary health care system. For instance, data are not available on the extent of 24 hour, 7 day a week on-call services by family physicians, or on the number of full-time equivalent primary health care professionals in the Region. Additional data collection will be required to support further planning and system development.

1.5 Health Status of Hamilton-Wentworth Residents

Primary health care professionals, who are often the first point of contact for consumers in need of health care services, must respond to the unique and various health needs of a population. The health of a population can be assessed using a number of methods. Two methods will be used to assess the health of Hamilton-Wentworth residents. The first is a global indicator of health where residents rate their health using a scale from “excellent” to “poor”. This is called self-reported health status. The second approach is a review of outcome indicators (morbidity and mortality rates) which measure the end result of health care services and, to some extent, the level of health service need in the community. Some relevant indicators describing the social and economic health of residents are initially presented.

1.5.1 Some Characteristics of the Population of Hamilton-Wentworth

- 24% of the population are immigrants⁴
- 2 % of the population cannot speak English; the most common languages spoken are Italian, Polish and Portuguese⁵
- 8,090 of residents are French-speaking persons; the City of Hamilton is a designated area for French Language Services⁶
- approximately 15% of the population of the Region live below the Statistics Canada low income cut-off line. The cities of Hamilton (18.2%) and Stoney Creek (9.5%) have the highest incidences of families with low incomes within the Region.⁷
- 1 in 7 residents of Hamilton-Wentworth between the ages of 16 and 69 has difficulty reading and writing⁸
- for 23.2% of the residents of Hamilton-Wentworth, the highest educational degree is a secondary certificate and 14.9% have a university degree; Ancaster (31.5%) and Dundas (26.7%) have the highest rates of the population with university degrees⁹
- Hamilton (15.8%) and Dundas (11.1%) have the highest numbers of one parent families; the average number of one parent families is 13.4% in the Region¹⁰
- in the Region, 75% of seniors over 65 years of age live in Hamilton¹¹
- almost 50% of all falls requiring hospitalization between 1986 and 1991 occurred to seniors, with the majority occurring to females (74%)¹²
- between 1986 and 1990, motor vehicle crashes resulted in 2,054 hospital admissions and 29,275 days in hospital; acute care costs topped \$18.6 million¹³
- there are an estimated 160 homeless persons on any given day in the Region¹⁴

1.5.2 Self-Reported Health Status

Health status based on self-reports can be a valuable tool in assessing the health of residents of a community. This method allows an individual to give an overall measure of his/her health. Self-reported health status is a subjective evaluation by an individual, but studies have found that there is a correlation between self-reported health status and the more objective evaluations of morbidity and mortality.¹⁵

Self-reported health status data are contained in the Ontario Health Survey. It shows that the percentage of Hamilton-Wentworth respondents who identified their health status as excellent/very good, declines with age. (Table 1). The Ontario Health Survey also found that a greater percentage of low-income persons perceived their health status to be poor in comparison to people with higher incomes. Similarly, persons in professional and skilled occupations were more likely to rate their health status as excellent/very good in comparison to unskilled workers. Overall, the health status of Hamilton-Wentworth residents was very similar to that of all Central-West* residents.¹⁶

Table 1

Self-Perceived Health of Hamilton-Wentworth Residents, 1990			
Age	Excellent/ Very Good	Good	Fair/Poor
12-19	71%	22%	4%
20-44	64%	28%	7%
45-65	50%	34%	16%
65+	35%	36%	24%
Total (12+)	57%	30%	11%
Central-West	59%	29%	10%

Source: Ontario Ministry of Health, 1992

* The Central-West area includes the districts of Niagara, Haldimand-Norfolk, Brant, Halton, Wellington, Dufferin, Waterloo and Hamilton-Wentworth.

1.5.3 Standardized Morbidity and Mortality Rates

Standardized morbidity and mortality rates represent a picture of illness and death in a community based on a standard age and sex structure. By holding constant age and sex characteristics, it is therefore possible to make comparisons between communities with very different demographic characteristics, of their levels of sickness and death. Differences in standardized rates identify populations which have more or fewer cases of disease or death than their population would suggest. Specifically, rates over 1.00 indicate health problems greater than would be predicted to occur in the population. Rates under 1.00 indicate fewer health problems than would be expected to occur in the population.

Standardized Morbidity Rates (SMR)

Morbidity information is based on the number of hospitalizations for a specific condition. Therefore, the morbidity data include only reported cases. If a person has a disorder that is not diagnosed or treated, he/she will not be counted. The morbidity data should be considered only as an approximation of the incidence of a condition.

The morbidity information identifies only seven causes of hospitalization that have morbidity rates greater than 1.00. Of the seven, skin diseases (1.31), leukemia (1.27) and misadventures during medical care (1.19) are the cases where the morbidity rate is significantly greater than 1.00. Overall, the morbidity rate (0.85) is well below the expected rate for the Hamilton-Wentworth population. Also, Central-West morbidity rates are greater than the Hamilton-Wentworth rates for nearly all diseases included in the index.¹⁷

Table 2

Standardized Morbidity Rates (SMR) for Hamilton-Wentworth and Central West, 1992

Cause of Hospitalization	Hamilton-Wentworth SMR	Central-West SMR	Identification of which area has the largest SMR
INFECTIOUS DISEASES	0.79	0.90	Central-West
• AIDS	0.62	0.43	Hamilton-Wentworth
NEOPLASMS	0.81	0.93	Central-West
• COLORECTAL	0.77	0.96	Central-West
• LIVER CANCER	0.69	0.79	Central-West
• TRACHEA, BRONCHUS, LUNG	0.57	0.84	Central-West
• SKIN	1.31	1.09	Hamilton-Wentworth
• FEMALE BREAST CANCER	0.82	0.94	Central-West
• CERVICAL	0.61	0.78	Central-West
• PROSTATE	0.75	0.98	Central-West
• LYMPHATIC AND HAEMATOPOIETIC TISSUE	1.04	0.99	Hamilton-Wentworth
• LEUKEMIA	1.27	1.19	Hamilton-Wentworth
• BENIGN NEOPLASMS	0.93	0.94	Central-West
ENDOCRINE, METABOLIC, NUTRITION, IMMUNE SYSTEM	0.74	0.98	Central-West
• DIABETES MELLITUS	0.73	0.95	Central-West
BLOOD AND BLOOD FORMING ORGANS	1.10	1.08	Hamilton-Wentworth
MENTAL DISORDERS	0.66	0.91	Central-West
• PSYCHOSES	0.78	0.82	Central-West
• ALCOHOL DEPENDENCE SYNDROME	1.00	1.20	Central-West
• DRUG DEPENDENCE	0.60	0.98	Central-West
• DEPRESSION	0.00	1.22	Central-West

NERVOUS SYSTEM & SENSE ORGANS	0.66	0.87	Central-West
CIRCULATORY SYSTEM	0.91	1.01	Central-West
• HYPERTENSIVE DISEASE	0.76	1.00	Central-West
• ALL ISCHEMIC	1.04	1.04	Equal
• ACUTE MYOCARDIAL INFARCTION	1.06	1.06	Equal
• ALL OTHER ISCHEMIC HEART DISEASE	1.03	1.04	Central-West
• ALL OTHER HEART DISEASE	0.87	1.00	Central-West
• CEREBROVASCULAR DISEASE	0.70	0.91	Central-West
• ARTERIES, ARTERIOLES, CAPILLARIES DISEASES	0.96	1.03	Central-West
RESPIRATORY DISEASE	0.71	0.97	Central-West
• PNEUMONIA	0.85	0.98	Central-West
• INFLUENZA	0.30	1.07	Central-West
• COPD	0.60	0.93	Central-West
• ASTHMA	0.56	0.97	Central-West
• DIGESTIVE DISEASE	0.91	1.00	Central-West
• CHRONIC LIVER DISEASE & CIRRHOSIS	0.89	0.91	Central-West
GENITOURINARY DISEASE	0.91	1.03	Central-West
• COMPLICATIONS OF PREGNANCY	0.00	0.96	Equal
DISEASES OF SKIN & SUBCUTANEOUS TISSUE	0.83	0.94	Central-West
MUSCULOSKELETAL AND CONNECTIVE TISSUE	0.90	0.95	Central-West
• ARTHROPATHIES	0.95	0.96	Central-West
CONGENITAL ANOMALIES	0.72	0.96	Central-West
PERINATAL CONDITIONS	0.88	1.02	Central-West
ILL DEFINED CONDITIONS	0.80	1.03	Central-West

INJURIES AND POISONINGS	0.94	1.02	Central-West
• FRACTURES/DISLOCATIONS	0.95	0.99	Central-West
• HEAD INJURY	0.67	1.14	Central-West
• BURNS	0.84	0.93	Central-West
• POISONINGS	0.88	1.08	Central-West
SUPPLEMENTARY CLASS (EXTERNAL CAUSES)	0.98	1.00	Central-West
• TRANSPORT ACCIDENTS	0.75	1.08	Central-West
• PEDAL CYCLE ACCIDENTS	0.99	1.17	Central-West
• MOTOR VEHICLE ACCIDENTS	0.92	0.99	Central-West
• MOTOR VEHICLE NON- TRAFFIC	0.59	0.84	Central-West
• ACCIDENTAL POISONINGS	0.75	1.01	Central-West
• MISADVENTURES DURING MEDICAL CARE	1.19	0.96	Hamilton-Wentworth
• ACCIDENTAL FALLS	0.84	1.04	Central-West
• OTHER ACCIDENTS	0.80	1.00	Central-West
• SUICIDE	0.97	1.12	Central-West
• HOMICIDE AND INJURY	0.88	0.83	Hamilton-Wentworth
TOTAL	0.85	0.98	Central-West

Standardized Mortality Rates (SMR)

Mortality information is based on the main cause of death identified on medical certificates. The mortality table reveals that there are eight causes of death which have rates equal to or greater than 1.25 and identifies areas which require special attention. The exceptionally high mortality rates are for benign neoplasms (1.47), drug dependence (2.82), influenza (2.47), and misadventures during medical care (1.49). The overall mortality rate is 1.03 which indicates that the mortality rate is only slightly greater than expected for the Hamilton-Wentworth population. No pattern is evident when comparing Central-West to Hamilton-Wentworth mortality rates because each is greater for approximately half of the causes of death included in the index. Also, the overall mortality rates for Central-West and Hamilton-Wentworth are almost identical¹⁸.

Table 3

**Standardized Mortality Rates (SMR) for Hamilton-Wentworth and
Central West, 1992**

Cause of Death	Hamilton-Wentworth SMR	Central-West SMR	Identification of which area has the largest SMR
INFECTIOUS DISEASES	1.10	0.74	Hamilton-Wentworth
• AIDS	0.48	0.41	Hamilton-Wentworth
NEOPLASMS	0.95	1.02	Central-West
• COLORECTAL	0.85	0.94	Central-West
• LIVER CANCER	0.85	0.72	Hamilton-Wentworth
• TRACHEA, BRONCHUS, LUNG	1.03	1.09	Central-West
• SKIN	0.55	1.00	Central-West
• FEMALE BREAST CANCER	0.99	1.08	Central-West
• CERVICAL	0.84	0.75	Hamilton-Wentworth
• PROSTATE	1.00	1.13	Central-West
• LYMPHATIC AND HAEMATOPOIETIC TISSUE	0.86	1.02	Central-West
• LEUKEMIA	0.77	1.00	Central-West
• BENIGN NEOPLASMS	1.47	0.92	Hamilton-Wentworth
ENDOCRINE, METABOLIC, NUTRITION, IMMUNE SYSTEM	0.82	0.86	Central-West
• DIABETES MELLITUS	0.78	0.92	Central-West
BLOOD AND BLOOD FORMING ORGANS	0.40	0.74	Central-West
MENTAL DISORDERS	1.18	0.98	Hamilton-Wentworth
• PSYCHOSES	1.34	0.93	Hamilton-Wentworth

• ALCOHOL DEPENDENCE SYNDROME	0.88	0.82	Hamilton-Wentworth
• DRUG DEPENDENCE	2.82	1.33	Hamilton-Wentworth
• DEPRESSION	0.00	0.62	Central-West
NERVOUS SYSTEM & SENSE ORGANS	1.10	1.07	Hamilton-Wentworth
CIRCULATORY SYSTEM	1.10	1.06	Hamilton-Wentworth
• HYPERTENSIVE DISEASE	0.88	0.78	Hamilton-Wentworth
• ALL ISCHEMIC	1.17	1.12	Hamilton-Wentworth
• ACUTE MYOCARDIAL INFARCTION	1.25	1.07	Hamilton-Wentworth
• ALL OTHER ISCHEMIC HEART DISEASE	1.10	1.17	Central-West
• ALL OTHER HEART DISEASE	1.11	0.94	Hamilton-Wentworth
• CEREBROVASCULAR DISEASE	1.03	1.03	Equal
• ARTERIES, ARTERIOLES, CAPILLARIES DISEASES	0.69	0.87	Central-West
RESPIRATORY DISEASE	1.01	1.00	Hamilton-Wentworth
• PNEUMONIA	1.01	1.09	Central-West
• INFLUENZA	2.47	1.24	Hamilton-Wentworth
• COPD	0.99	0.95	Hamilton-Wentworth
• ASTHMA	0.99	0.82	Hamilton-Wentworth
• DIGESTIVE DISEASE	1.19	1.02	Hamilton-Wentworth
• CHRONIC LIVER DISEASE & CIRRHOSIS	1.21	1.02	Hamilton-Wentworth
GENITOURINARY DISEASE	1.30	1.00	Hamilton-Wentworth
• COMPLICATIONS OF PREGNANCY	0.00	0.90	Central-West

DISEASES OF SKIN & SUBCUTANEOUS TISSUE	1.10	0.83	Hamilton-Wentworth
MUSCULOSKELETAL AND CONNECTIVE TISSUE	0.96	1.06	Central-West
• ARTHROPATHIES	0.93	1.11	Central-West
CONGENITAL ANOMALIES	0.85	0.94	Central-West
PERINATAL CONDITIONS	0.70	0.81	Central-West
ILL DEFINED CONDITIONS	0.79	0.55	Hamilton-Wentworth
INJURIES AND POISONINGS	0.96	0.94	Hamilton-Wentworth
• FRACTURES/DISLOCATIONS	0.84	1.06	Central-West
• HEAD INJURY	0.98	0.83	Hamilton-Wentworth
• BURNS	0.96	1.08	Central-West
• POISONINGS	1.17	1.17	Equal
SUPPLEMENTARY CLASS (EXTERNAL CAUSES)	0.96	0.94	Hamilton-Wentworth
• TRANSPORT ACCIDENTS	0.87	0.66	Hamilton-Wentworth
• PEDAL CYCLE ACCIDENTS	0.00	1.02	Central-West
• MOTOR VEHICLE ACCIDENTS	1.17	0.89	Hamilton-Wentworth
• MOTOR VEHICLE NON-TRAFFIC	0.49	0.34	Hamilton-Wentworth
• ACCIDENTAL POISONINGS	1.35	1.11	Hamilton-Wentworth
• MISADVENTURES DURING MEDICAL CARE	1.49	1.17	Hamilton-Wentworth
• ACCIDENTAL FALLS	1.07	1.07	Equal
• OTHER ACCIDENTS	0.58	0.84	Central-West
• SUICIDE	0.59	0.87	Central-West
• HOMICIDE AND INJURY	1.00	0.78	Hamilton-Wentworth
TOTAL	1.03	1.01	Hamilton-Wentworth

1.6 Primary Health Care - Description of Current Services and Resources

Hamilton-Wentworth has a mix of primary health care organizations, community-based primary health care services and primary health care professionals. These are described below. Data are also provided on primary health care expenditures and the utilization of primary health care professionals. Unless otherwise indicated, all data are from the Ministry of Health.

1.6.1 Primary Health Care Organizations

Community Health Centres (CHC's)

There are currently three (3) community health centres in Hamilton-Wentworth - the North Hamilton Community Health Centre, The Centre de Santé et de Services Communautaires - Hamilton, and the Urban Core Community Health Centre. Community health centres provide primary health care services and health promotion programs which focus on groups of people who may have difficulty accessing services or have a higher burden of illness. They also link with other services such as housing, employment, and education. The North Hamilton Community Health Centre provides primary care services to residents of north end Hamilton and has developed expertise in assisting persons with HIV/AIDS, ethno-cultural groups and those with low incomes. The Centre de Santé et de Services Communautaires - Hamilton provides services to our Francophone population. The Urban Core Community Health Centre, which is now in a start up phase, will provide some services for homeless, underhoused, low income and culturally diverse persons by Spring 1996.

Health Service Organizations (HSO's)

Of the province's 77 HSO's, 37 are in Hamilton-Wentworth. Approximately 120,000 people are rostered with them which represents about one quarter of the residents of the Region. HSO's receive capitation funding to provide health services to rostered patients. Health related services, such as nutrition, nursing and counselling, etc., may also be provided. Currently, in Hamilton-Wentworth some HSO's have received funding for mental health and nutrition services. HSO's are required to have 24 hour on-call services and to be open 40 hours per week. HSO's can be sponsored by physicians, the community or hospital based organizations. The Faculty of Health Sciences sponsors 3 HSO's. Currently 80 physicians have HSO contracts and there are an additional 8 employee physicians working in physician sponsored HSO's. There are approximately 13 employee physicians in the university sponsored HSO's.

Independent Health Facilities (IHF's)

There are 45 active licenses for independent health facilities in Hamilton-Wentworth. Independent health facilities provide diagnostic services, such as ultrasound and radiology, and ambulatory health services, such as cataract surgery.

Episodic Care Services

Episodic care services, such as walk-in clinics and house call services, provide medical care without the need for an appointment. Data are not available on the number of these services in the Region nor the utilization of these services.

Urgent Care Centres and Emergency Room Departments

Although not specifically designed as places to receive primary medical care, the Region's two Urgent Care Centres and four Emergency Room Departments do provide necessary primary medical care to residents in this Region. Data indicate that in 1995, 12.3% of patients seen in Emergency Departments were initially triaged by nursing staff as "deferrable/elective", meaning that they did not require treatment within a 24 hour period. Overall, after a comprehensive assessment was done by a physician, it is estimated that approximately 40% of patients seen in emergency departments could have been seen in a primary health care setting.¹⁹

1.6.2 Community Primary Health Care Services

Home Care

Home Care provides nursing, homemaking and allied health services to those who require care to avoid or to substitute for hospitalization, to avoid or delay chronic or long-term institutional care and to prevent or delay functional deterioration. Services are also provided to physically and mentally challenged children who require care at home or at school. In 1993/94 the caseload for Home Care was 13, 261 people in the acute, chronic and school programs.

Department of Public Health Services (DPHS)

The Department of Public Health Services is responsible for communicable disease control and prevention and health promotion work in the mandated areas of healthy growth and development, healthy lifestyles and healthy environments.

The Department of Public Health Services has extensive involvement with individuals and community groups and with education and research. To name only a few examples, 92,000 school aged children are being immunized against measles in 1996. Nursing Services had 69,121 contacts through home and school visits and telephone contacts in 1994. In the same year, The Nutrition Resource Centre responded to 2,481 requests for information and 741 people requested assistance from the Substance Abuse Program. Also in 1994, the DPHS was also involved with 35 externally funded research projects.

Health Information Telephone Lines

Three local health information lines currently exist in Hamilton-Wentworth providing health education and information to callers. St. Joseph's Community Health Centre operates Health Extension. Callers are given health information through a tape recorded message on 420 health topics. From April 1994 - March 1995, 62,030 calls and 1,689 requests for mailed information through the related service of the Consumer Health Information Centre, were received.²⁰ The Department of Public Health Services operates two lines - the STD (Sexually Transmitted Diseases) Information Line and the Parent-Child Health Information Line. In 1994, 1,334 and 4,063 calls were received respectively by these lines. Callers speak with a nurse who responds to specific questions.²¹

Cancer Information Services is a provincial information line located in Hamilton which responds to individual inquiries.

1.6.3 Other Primary Health Care Services

There are community mental health and addictions services in the Region providing health promotion, health education, treatment and counselling services. Community reports indicate that existing community health services are inadequate to meet the needs of consumers/survivors of mental health services and those with addictions.^{22,23}

Hamilton-Wentworth also has dozens of non-profit organizations providing advice, peer support and instrumental services to their members who have specific diseases, such as cancer, diabetes or colitis to name only a few examples. These organizations receive funding from a variety of sources.

1.6.4 Primary Health Care Professionals

Family Physicians/General Practitioners

Family physicians and general practitioners work in CHC's, HSO's and in solo and group practices. In 1994 there were 416 general practitioners and family physicians in Hamilton-Wentworth (this number does not reflect full-time equivalents). The ratio of these physicians to the population is 1:1,176.

Some data exist on family physician practice distribution in Hamilton-Wentworth (see Appendix 1). The majority of family physician practices in 1993 were in the City of Hamilton. Conversely few physician practices exist in the Township of Glanbrook. Concern about the limited number of family physicians in this area has been expressed in the past to the Hamilton-Wentworth District Health Council.²⁴

Nurses

There were 4,536 nurses working in Hamilton-Wentworth in 1994. About 501 work in a primary health care setting, such as the public health department, a physician's office or a community health centre. (This number includes 255 Home Care and visiting care nurses. Primary health care is not provided by all of these nurses, all of the time) ²⁵ *

Other Primary Health Care Professionals

There are a range of other primary health care professionals working in the Region. Data are not available on the settings in which they work. Listed below however, are the number of professionals from each discipline working in both the public and private sectors in the Region in 1994:

<u>Type</u>	<u>Number *</u>
Chiropractors	59
Dentists	239
Dental Hygienists	159
Dieticians	70
Midwives	9
Physiotherapists	259
Psychologists	72
Optometrists	38
Pharmacists	490
Occupational Therapists	218
**Social Workers	240

* not full time equivalents; data sources are from each of the respective professional colleges

** only reflects the number who are voluntary members of the Ontario Association of Social Workers

1.6.5 Utilization of Primary Health Care Professionals

Table 4

Percent of Population with at least One Contact with Health Professionals during Past 12 Months, 1990					
Age	General Practitioner	Specialist	Dentist	Nurse	Optometrist
0-11	83%	30%	63%	6%	12%
12-19	83%	21%	74%	7%	30%
20-44	78%	28%	70%	9%	27%
45-65	82%	35%	66%	8%	37%
65+	88%	43%	44%	10%	43%
Total	81%	31%	65%	8%	29%
Central-West	83%	31%	67%	11%	35%

Source: Ontario Ministry of Health, 1992

The Ontario Health Survey data regarding health professional utilization rates for Hamilton-Wentworth, reveal that general practitioners (81%) and dentists (65%) are consulted by the majority of the population (Table 4). Specialists, optometrists and nurses are less commonly consulted by the population²⁶.

A more recent District Health Council survey of Hamilton-Wentworth residents indicated that 87% of those surveyed had had contact with their family physician in the last year. Also, 67% of residents had gone to their family physician/general practitioner two or more times during the last year²⁷.

Age, sex and income are all factors in a person's tendency to consult a health professional. For instance, in the Ontario Health Survey, seniors and the very young reported higher utilization rates for several of the health professional categories, in comparison to adolescents, young adults and middle aged persons. Women were also more likely to see some health professionals than men. For example, 87% and 76% of females and males had respectively consulted a family physician in the past year²⁸. Income also has been noted as a factor in health professional utilization, although the relationship is not a consistent one for all types of services. In the 1995 District Health Council survey of Hamilton-Wentworth residents, the results revealed that higher income earners were more frequent users of homeopaths, naturopaths and massage therapists²⁹.

In comparing Hamilton-Wentworth health professional consultation rates to those for the entire Central West Region, Hamilton-Wentworth was slightly below the rate for four out of five categories. Use of specialists is the only category where Hamilton-Wentworth utilization was equal to the rate for the entire Central-West Region³⁰

1.6.6 Primary Health Care Expenditures In Hamilton-Wentworth

The following are the expenditures in primary health care in Hamilton-Wentworth based on the most recent data available. (Unless otherwise indicated, data are from the Ministry of Health.)

Table 5

Community Health Centres (1992/93)	\$ 2,117,000
Health Service Organizations (1994/95)	22,824,219
Nutrition and Mental Health Networks in HSO's	1,063,726
Fee for Service Family Physicians (1993/94)	53,599,400
Health Promotion (1992/93)	335,727
Independent Health Facilities - Facility Fees (1994/95)	6,418,724
Department of Public Health Services (1995)	*17,327,670
Home Care (1994/95)	**40,924,467
* includes municipal funding and funding from other sources; data from the DPHS	
**includes a one time funding adjustment of 1,000,000; data from Home Care	

2.0 STRENGTHS AND WEAKNESSES OF PRIMARY HEALTH CARE IN HAMILTON-WENTWORTH

2.1 The Perspective of Primary Health Care Professionals

The following is a synopsis of local issues in primary health care which were identified through focus group consultations, key informant interviews and written submissions to the Primary Health Care Working Group by a range of primary health care professionals. Local data and research to support the issues raised are also included.

Primary Health Care as The Foundation of Health Care

It was noted that primary health care is the foundation of the health care system. If primary health care is well integrated, coordinated, accessible and comprehensive, it has the potential to maintain and enhance health. It can also create cost efficiencies by preventing unnecessary entry to secondary and tertiary care. When secondary and tertiary care are required, an effective primary health care system can help to ensure the best use of these more costly services by referring patients to the most appropriate services and providers.

Availability of Primary Medical Care Services

Primary medical care is widely available in the Region through multiple access points. Residents can receive primary medical services through family physicians / general practitioners who work in solo and group practices, in HSO's, CHC's, Walk-In Clinics, House Call services and through urgent care centres and emergency departments. Health information can also be obtained through health information telephone services and through other primary health care professionals, such as pharmacists and public health nurses.

Given that primary medical care is widely available to residents of the Region, lack of continuity of care and duplication of services (and therefore increased costs) can become problems. For example, a resident may visit an emergency department and then his/her family physician for the same medical problem. This may result in the duplication of diagnostic tests and drug prescriptions.

Although primary medical care is widely available, some populations, such as the homeless, those with addictions, consumers/survivors of mental health services and victims of violence find that there are a lack of primary health care services to meet their specific needs.³¹ Other research shows that there are ethno-cultural barriers to using health services for various ethnic and cultural populations.³² Our Francophone population also has difficulty accessing French-speaking physicians.

Accessibility of Primary Health Care Services

Accessibility, or the degree to which one is able to secure primary health care services, is also an issue in Hamilton-Wentworth.

More specifically, some family physicians / general practitioners do not have on-call coverage or flexible office hours. (There are no current data to show to what extent this occurs in Hamilton-Wentworth.) This can result in the use of episodic services, such as emergency departments or walk-in clinics by consumers. For example, the Emergency Services Review study reported that 92.5% of those surveyed had a family doctor. Approximately one third of respondents had attempted to contact their family physicians prior to going to the emergency department and of these, 70% could not access their physicians.³³ Current research also shows that many patients seen in emergency departments could be seen by a family physician. For instance, 12.3% of emergency room patients are initially triaged as “deferrable/elective” by nurses. After an assessment by a emergency room physician approximately 40% of all patients are deemed “deferrable/elective”.³⁴ Some visits to emergency departments are clearly driven by consumers wanting quick and convenient access to primary medical care. Some visits to emergency departments however, occur because access to 24 hour, 7 day a week primary medical care, through a consistent provider or group of providers, does not exist for all residents of the Region.

Another issue in terms of access, is that some services are available in the private sector, such as some physiotherapy services, nursing services, dentistry and chiropractic services. This means that those who cannot afford these services, or do not have insurance coverage, cannot access these types of primary health care services

Access to other primary health care professionals in the community, such as dietitians, is also variable. Some primary health care organizations, such as HSO’s and CHC’s, employ a range of allied health professionals. For residents not affiliated with these organizations, access to some allied professionals may be limited.

Communication Among Health Care Providers

Communication can be enhanced among primary health care providers. It can also be enhanced between primary health care providers and others in health care. Family physicians report that other practitioners, such as specialists and hospital personnel, do not consistently provide them with timely and sufficient information about their patients. It also appears that the potential of information technology to enhance communication has not been fully explored or utilized in the Region.

Coordination of Care

One of the essential functions of primary health care is to coordinate the care of consumers. This serves to provide comprehensive care and access to needed social, community health, secondary and tertiary services. Traditionally, family physicians have viewed themselves as providing this function but some fee-for-service physicians are identifying that barriers, such as lack of time, lessen their ability to effectively carry out this role. For example, family physicians are involved in communicating with specialists, accessing and coordinating services and monitoring a patient's care when he/she is referred to another service. These activities are time consuming and a fee-for-service payment system does not remunerate physicians for these functions. Currently, there is also some debate as to whether other primary health care professionals should have an enhanced role in coordinating non-clinical care.

Interdisciplinary Teams

There was strong, although not unanimous, support in the focus groups for the use of interdisciplinary teams in primary health care in Hamilton-Wentworth. Some debated whether interdisciplinary teams are cost effective. Others noted that interdisciplinary teams maximize the range of skills and interventions possible to respond to the needs of consumers. Where interdisciplinary teams have been used to date, they have included a range of primary health care providers, such as physicians, nurses, nurse practitioners, dietitians, mental health workers, chiropodists and physiotherapists. In these teams, leadership in the care of patients is shared and can vary from one professional to another depending on the needs of the patient.

Common Patient Record

It was recommended that a common patient record be developed which would contain patient histories and medical interventions. This would avoid costly duplication of services and would improve continuity of care because health care providers would be equipped with current information on their patients. Concerns over confidentiality and who controls access to the information were raised.

Health Promotion / Disease Prevention

Consensus existed among primary health care providers in the focus groups for placing an increased emphasis on health promotion and disease prevention. Health promotion is seen as more than services or programs. It is seen as a philosophy which should permeate health care delivery. Health promotion/disease prevention, therefore should occur at the primary, secondary and tertiary levels. It was emphasized that the broad determinants of health must be supported and addressed because health is largely determined by other factors, such as an adequate income and housing, etc.

Planning / System Development

Currently, primary health care is not viewed as a “system” by local providers. Rather it is described as a series of fragmented programs, services and health professionals. The need to plan for the development of a coordinated primary health system which connects to other components of the health care system was emphasized. The development of an enhanced primary health care system should begin with the definition of a vision for an effective primary health care system and the establishment of common primary health care goals that are reviewed and monitored on a continuous basis.

Data / Research / Information

The need for evidence based, best practices data was identified. Data on population needs and effective strategies to respond to population needs are also required.

It was also noted that little local data exist on primary health care and its components. Data collection is required to better describe the components of the primary health care system, how it is utilized and its gaps.

Up-to-date and easily accessible information is also needed by primary health care providers, and particularly physicians, about community resources so that they can effectively refer to existing resources.

2.2 The Perspective of Consumers on Primary Health Care

The Health Action Task Force solicited the views of citizens of Hamilton-Wentworth about the health care system using a variety of mechanisms. These included a 1-800 number, comments written on the tear off portion of a newspaper supplement, eight open houses where attendees were encouraged to complete questionnaires and through written briefs and letters. Citizens had the opportunity to comment generally or to respond to some of the preliminary ideas of the Health Action Task Force.

The following are the themes from community members regarding primary health care. Where possible, quotes have been used to reinforce the views of community members.

Maintain consumer choice and access to family physicians

The need to ensure access to and choice of one's family physician was stressed by consumers. It was noted that consistent health care which is based on history and trust is essential. One person noted, "I want to have a choice in the person I can place confidence in".

Health Education / Health Promotion / Disease Prevention

Consumers concur with primary health care professionals that a greater emphasis is required on self care, health education, disease prevention and health promotion. Consumers noted that:

"if doctors, therapists or any other health care people, like nurses, would take time to explain the procedure, operation or medication and educate as to why it is being done and what the patient can do to help themselves or how to prevent it from happening again, perhaps time and dollars would be saved in the long run"

"strategies are needed to help citizens develop responsibilities for their own health"

"mind and body can be strengthened and healed . . . education and training is needed in order to promote quality of life"

"(we) need a healthful community".

Interdisciplinary Care

Community members also raised the issue of improving access to alternative health providers and improving access to a broad range of primary health care providers. Consumers indicated that interdisciplinary team members should include psychologists, naturopaths, massage therapists, nurse practitioners, counsellors, physiotherapists, occupational therapists and midwives.

Accessibility to 24 hour, 7 day a week primary medical care

Consumers indicated that access to 24 hour, 7 day a week primary medical care through their family physicians is important. Sometimes this is not available:

“doctors (should) have at least one night a week for patients who cannot take time off work during the day”

“I think that if doctors were open later that would help because I find that I’m at the emerg at night, or the weekends and my doctor’s closed by the time my spouse is off work at night”.

For others 24 hour, 7 day a week care is available:

“One thing that really got my interest was providing 24 hour on call services. I already have that. My doctor works in a medical arts building with many other doctors. If he is on vacation or just can’t be there, one of the other doctors in the building can help you through the use of an answering machine. This care is around the clock”.

Common Patient Record

There is considerable support for developing a common patient record that would be used by health care providers. As with primary health care providers, the issues of confidentiality and security of the system were emphasized:

“Confidentiality must be assured and I would demand access at any time for review (accuracy, current).”

Community Based Care

Community members expressed overwhelming support for providing more community care as opposed to hospital care. The need for additional home care and community care services and the need for additional funds for these services were emphasized:

“More home care as opposed to hospital care would be easier for the patient and the cost being less, more people could be serviced.”

Neighbourhood Primary Health Care Networks

One of the preliminary ideas of the Health Action Task Force was the proposed development of neighbourhood primary health care networks. Consumers wanted further clarification about the role, composition, costs and implementation of the networks. In spite of this, there was some support for this model:

“I think the idea of grouping health providers and services is a good idea. People of all ages and the elderly would have access to a wider variety of services if it were combined.”

“Excellent idea, this can be more efficient and provide a more personal and caring way to provide health care.”

2.3 SUMMARY OF THE STRENGTHS AND WEAKNESSES OF THE PRIMARY HEALTH CARE SYSTEM

Strengths of the primary health care “system” in Hamilton-Wentworth:

- a range of dedicated primary health care professionals who work in a variety of practice settings
- a mix of practice settings (solo, group practice, CHC's and HSO's) which provide a range of options for consumers
- a large number of HSO's, which enhance access to interdisciplinary care and provide improved access to on-call services
- informal communication and linkages due to the relatively small size of our community
- the Faculty of Health Sciences uses a primary health care model as a basis for its teaching program
- experimentation and innovation in the health care system exist, as evidenced in the development of a Quick Response Service*, transitional beds and Interservice teams**
- multiple points of access to primary health care provides consumers with choice and convenience
- there are academic linkages with family practice
- many physicians provide 24 hour, 7 day a week on-call coverage to their patient populations
- coordination exists through a committee of the Chiefs of Family Medicine and the Academic Chair of Family Medicine
- collaborative models of care exist; for example, in some family practice units, nurse practitioners and physicians work together

* The Quick Response Service provides an assessment of patients who present at emergency room departments and refers them to the Home Care Program, supportive beds or community services to prevent or avert unnecessary hospitalization

** The Interservice Team is a pilot project of the Community Coalition of Health and Support Services which coordinates services and providers in a geographically based team

Weaknesses of the primary health care “system” in Hamilton-Wentworth

- multiple points of access to primary medical care can result in duplication of services, increased costs and discontinuous care
- the lack of availability of appropriate primary health care services for some populations (e.g. Francophone persons, homeless persons, etc.)
- the lack of access to 24 hour, 7 day a week primary medical care by a consistent family physician or group of physicians for some residents of the Region
- the lack of access to some primary health care professionals, such as dietitians
- lack of communication and coordination within primary health care and with other components of the health care system (e.g. acute care)
- lack of a common patient record
- inadequate emphasis on health promotion/disease prevention
- lack of a primary health care planning mechanism
- fragmentation among professionals and of services
- lack of data on the primary health care system, evidence based research and population health based data and targets

3.0 STRATEGIES

The following strategies are proposed to respond to the local issues in primary health care which were identified in the consultation process.

3.1 Community Primary Health Care Networks

In order to build on the strengths of the local primary health care “system” to provide comprehensive and coordinated individual care and to ensure a population health perspective in primary health care it is recommended:

That community primary health care networks be developed and piloted.

Description of Community Primary Health Care Networks:

The Networks are:

- Patient focused
- Voluntary
- Without Walls
- Support patient choice of family physician
- Based on secondments
- Use current resources
- Interdisciplinary
- Linked to other components of the health care system
- Reflect the unique needs of the community
- Are supported by team facilitators

Goals of the Networks

- To support the provision and coordination of individual primary health care
- To support the development of a population health perspective in primary health care by identifying goals, targets and strategies.
- To support the implementation of health promotion strategies in a coordinated way at the individual, group and community level.
- To support the provision of 24 hour, 7 day a week access to primary medical care services to the residents within a geographic boundary.
- To support enhanced communication between primary health care providers.
- To support the coordination of care between health and social service providers

Possible Membership of the Community Primary Health Care Networks

- family physicians
- Home Care
- Department of Public Health Services
- local primary health services (e.g. HSO's, CHC's, Independent Health Facilities)
- local community based allied health providers (e.g. dentists, chiropractors, physiotherapists, pharmacists, etc.)
- local long-term care services
- local housing developments, churches, schools, libraries, recreation centres, etc.
- other relevant Regional services (e.g. mental health, addictions services, General Welfare, DARTS, etc.)

The membership of each network will vary to match the unique needs of the community served. For instance, a community with high numbers of elderly persons would benefit from the support of geriatricians, psycho-geriatricians, chiropodists and those who can respond to the issues of isolation and lack of family supports, etc. Networks need to ensure access to both skills and services.

Access To The Networks

Consumers can access the networks through the range of primary health care providers who are involved with the network. Therefore, physicians, the Home Care Program, or a community pharmacist, etc. could be entry points to the range of other services or providers in the network.

Linkages To Support The Community Primary Health Care Networks

Linkages are required with specialists, the Faculty of Health Sciences, acute care hospitals, urgent care centres, emergency departments and data resources.

Pilot Sites

Three pilot sites are to be selected by a Design/Implementation Committee. The sites should reflect the urban and rural diversity of the Region and should include some areas which have high risk populations. The size of the pilot sites requires further consideration to accommodate both service delivery and population health initiatives. Pilot sites could also explore different models of providing 24 hour 7 day a week on-call coverage (e.g. on-call groups and/or access to a telephone health information service, etc.) Pilot sites should also build on and complement existing models, such as the Interservice Team, CHC's and HSO's, etc.

Implementation

A Design/Implementation Team is required to be responsible for further definition of the model, selection of pilot sites, identification of the optimal size of pilot locations for service delivery and population health strategies and engaging local partners. The Design/Implementation Team would be composed of local primary health care providers and representatives from other components of the health care system, such as those in emergency departments.

Estimated Costs of A One Year Pilot of Three Pilot Sites

Development Costs

Design Team Staff person (part-time, 6 months)	\$30,000
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Evaluation of Three Pilot Sites	\$25,000
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Operational Costs for Three Pilot Sites

a) One Time Costs

Hardware / Software for Information Systems	\$ 35,000
Team Trainer	4,000

b) Ongoing Costs

Population Health Data Collection	\$ 20,000
Training of Interdisciplinary Team Members	30,000
Meeting / Administrative Costs	11,000
Outreach / Program Development Costs	36,000
Stipend for Team Facilitators (will be seconded from a participating agency)	9,000

* Total	<u>\$200,000</u>
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* Where possible, some of the costs to support the networks will be borne by those participating in the networks

3.2 Health Promotion / Disease Prevention

Integrated health systems must ensure that comprehensive health services are provided to a population. Disease prevention/health promotion is fundamental. It is therefore recommended:

That a percentage of the savings realized through local health care restructuring be re-directed to health promotion and disease prevention.

Rationale

There is great value in focusing health care expenditures on health promotion/disease prevention. Data clearly indicate that health is influenced by many factors, such as socioeconomic status, employment and the environment. For instance, research shows that those with low incomes die earlier, have more frequent periods of sickness and disability and report being less happy³⁵. Higher death rates are also found among those who are unemployed and there is a strong relationship between lower socioeconomic status and low birth weight babies. Some research has shown that air pollution results in higher hospital admissions because of respiratory problems³⁶.

Other research shows that some hospital admissions are avoidable or preventable. The Health Systems Agency of New York City Inc. developed an Ambulatory Care Sensitive Index (ASC) which "includes age and sex adjusted admission rates for illness, which the patient might not develop, if regular health screenings and preventive care were obtained; and which could be managed if comprehensive primary medical services were available, thus reducing acute episodes of illness, and in many cases, mitigating the need for acute care hospitalization"³⁷. Such sicknesses included adult bronchitis/asthma, gangrene, heart failure and diabetes. Some hospital admissions might also be reduced over a period of 2 - 3 years with changes in health habits as a result of health promotion/disease prevention initiatives. Some of these sicknesses include some malignant neoplasms of the skin, lung cancer and immunizable conditions³⁸.

Research also demonstrates that morbidity can be reduced and health behaviours can be improved as a result of health promotion / disease prevention at the community level. For example, some community based health promotion programs have been successful at reducing cardiovascular risk³⁹. Also, consumer education about the self management of health problems can lower the use of health services between 7 - 17% by providing practical information and increasing consumer self confidence about health decisions⁴⁰.

Workplace disease prevention/health promotion programs have also been shown to reduce morbidity, decrease employer health care costs, decrease sick days and improve employee health behaviours^{41, 42}.

The cost of health promotion / disease prevention initiatives can be relatively minor or expensive, depending on the nature and scope of an intervention. For example, some disease prevention programs may be more expensive than treatment depending on the type and frequency of the intervention, the size of the program and the individuals involved. The need for evaluations to assess the efficacy of disease prevention / health promotion interventions and cost effectiveness is paramount⁴³

Currently, in Hamilton-Wentworth, disease prevention and health promotion programs are being provided at the primary, secondary and tertiary levels by a range of health providers. Services include screening and immunization programs, education and community development. The Department of Public Health Services is mandated to provide disease prevention and health promotion programs to the residents of the Region and has effectively done so at the individual, group and community level.

In 1992/93 less than 1% of the Ministry of Health's funding to Hamilton-Wentworth went to health promotion. Overall, the need for more health expenditures on health promotion/disease prevention programs at the primary, secondary and tertiary levels is required. Funding should also be directed toward evaluating interventions and which target populations benefit most from specific interventions.

3.3 Common Patient Record

A common patient record is an essential feature of an integrated health care system because it ensures continuity of care and system wide communication through centralized, standardized information. It is therefore recommended:

That a common patient record be supported and developed.

Rationale

The development of a common patient record has benefits for patient care, for providers, for system wide data collection and for the reduction of health care costs. Quality of care and continuity of care is facilitated by a common patient record. Patients who receive care from different health providers in different locations can be assured that all relevant medical information is documented in this record. This is particularly beneficial for patients who are critically ill or are otherwise unable to pass along medical information. Health providers benefit because a common patient record ensures that medical decisions are based upon complete medical information⁴⁴. Population health data can also be collected through a common patient record. Finally, health care costs can be reduced by avoiding the duplication of tests and reducing data entry.

Currently, there are three initiatives underway to pilot, develop or explore a common patient record. These are a) the HAPPIN Project*, a Hamilton-Wentworth initiative; b) the Clinical Practice Management Network, a pilot study of the College of Family Physicians of Canada; and, c) the Smart System, by the Ministry of Health.

Legislative direction is required on the transfer of patient information between health agencies without patient consent. In addition, general issues regarding confidentiality and where the common patient record resides (i.e. patient, primary care physicians, community data base, MoH) must be addressed.

* The HAPPIN Project (Hamilton Area Public and Private Information Network) is designed to develop an integrated health information network.

3.4 Reallocation of Health Care Funds To Community Care

As the health care system is restructured, and increased emphasis is placed on community care, it is recommended:

That a significant portion of the savings realized through health care restructuring be immediately reallocated to strengthening community care.

Rationale

Health care restructuring will place significant and additional demands upon formal and informal caregivers, primary health care services and on the range of long-term care services. More patients with greater acuity of illness and with complex needs will remain in the community for care or will be transferred back to the community for care more quickly. Adequate funding is critical for home support services and the entire range of primary health, community mental health, community addictions and continuing care services to ensure the viability and integrity of a sustainable health care system

3.5 Education

The ongoing education of the entire community about disease prevention/health promotion, health care services, their costs and appropriate utilization is needed to ensure the efficient and effective use of a sustainable, integrated health care system. It is recommended:

That a range of community partners, such as the health sector, the educational sector, citizens, employers and employer representatives, like the Chamber of Commerce and the Employer Committee on Health Care-Ontario*, collaboratively design an ongoing community education strategy focusing on disease prevention/health promotion and the effective and efficient use of health care resources in Hamilton-Wentworth.

Rationale

Ongoing education about disease prevention/health promotion, self care, self limiting illnesses and how and when to access local health care services is beneficial for the sustainability of local health care resources. Health care providers have a key role in providing this education in collaboration with those who have skills in education and those who can facilitate access to citizens in the community. For example, work sites provide many opportunities for health education. As has been previously noted, workplace disease prevention/health promotion programs have been shown to reduce morbidity, decrease employer health costs, decrease sick days and improve employee health behaviours

* is a group of over 30 of Ontario's largest employers (e.g. Stelco, Dofasco) which identify opportunities to improve the effectiveness of employer-sponsored programs and propose changes to improve health care in the province

3.6 Governance, Management and Coordination

A mechanism is required to plan for the ongoing development of a coordinated primary health care system which is integrated with other components of the health care system. It is recommended:

- a) **That a Health Systems Review Board, which is responsible for the regional management, planning and evaluation of health services, be struck;**
- b) **also, that the Health Systems Review Board strike a primary health care sub-committee; that this committee include, but not be limited to, consumers, the Chiefs of Family Medicine, the Academic Chair of Family Medicine, the Chair of the Family Medicine Committee of the Academy of Medicine, the Department of Public Health Services, Home Care and allied primary health care providers; that this committee be mandated to work cooperatively with primary health care providers to articulate a vision for the enhancement of the primary health system, develop goals and strategies for coordination and communication, collect local, relevant primary health care data, evaluate the primary health care system and coordinate with other relevant components of the health care system.**

Rationale

Presently, a community based primary health care coordinating body with primary medical professionals and allied health professionals does not exist. Given this, there are no formalized links between primary health care and other components of the health care system. Opportunities for research, enhanced communication, coordination and education can be facilitated through the development of a primary health care coordinating body.

3.7 Provincial Reforms On Primary Medical Care

Family physicians and general practitioners are essential to the effective functioning and use of both primary medical care services and more costly secondary and tertiary care. Barriers exist that prevent them from fully providing a range of primary medical services to the desired extent for their patient populations. It is recommended

That the Ministry of Health support the development of patient rostering and modify the current fee for service system by providing the option for alternative funding mechanisms.

Rationale

The benefits of patient rostering are clear. It facilitates a relationship of mutual accountability between the family physician and the patient. Family physicians, for instance, are required to provide comprehensive services to rostered patients. In return, patients agree to receive these comprehensive services from the selected family physician. Choice of family physician is inherent in patient rostering because the patient initially selects the family physician. Patients can also change or become rostered with another family physician. With rostering, family physicians are also better able to respond to the various needs of a defined population by having a clearer understanding and description of the patient population.

Alternate funding mechanisms enhance the ability of family physicians to more fully provide a range of services for their patient populations. For example, it would enhance the ability of fee for service physicians to do health promotion / disease prevention, coordinate care, provide 24 hour, 7 day a week on-call coverage, engage in research and community initiatives and fully respond to those requiring complex care. Alternate funding mechanisms would more adequately and specifically compensate physicians for these varied and necessary functions.

4.0 IMPLEMENTATION

Numerous local issues and suggestions regarding the enhancement of the local primary health care system have been identified in this consultation process. A Health Systems Board with a Primary Health Care Sub-committee has been recommended to respond to these issues. Until such a time as this occurs, it would be useful to immediately address some of the issues raised in this report. It is therefore recommended

- a) **that the Hamilton-Wentworth District Health Council strike a primary health care committee**
- b) **that this committee include members such as consumers, the Department of Public Health Services, Home Care, relevant community based primary health care services, the Chiefs of Family Medicine, the Academic Chair of Family Medicine, the Chair of the Family Medicine Committee of the Academy of Medicine and a range of allied primary health care providers**
- c) **that this committee work collaboratively with those in primary health care to facilitate the development of an enhanced primary health care system; also that this committee collect relevant data for planning purposes, and evaluate the various elements of primary health care**
- d) **that this committee work collaboratively with other relevant committees of the Hamilton-Wentworth District Health Council so that planning and integration can occur across all components of the health care system.**

Rationale

As has been noted throughout, primary health care is the cornerstone of the health care system. This perspective should be reflected in the work and planning done by the Hamilton-Wentworth District Health Council. Currently, no committees of the District Health Council focus specifically on primary health care or primary medical care. Committees which address health promotion, long-term care and acute care do exist. A primary health care committee would ensure a necessary primary health care focus in the health planning done by Council.

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- 37 . Cited in MTDHC Hospital Restructuring Project Supplementary Report, Appendix 5, 1995 pp 11-13
- 38 . Ibid , pp 11-13
- 39 . Pelletier K., "A Review and Analysis of the Health and Cost Effective Outcome Studies of Comprehensive Health Promotion and Disease Prevention Programs at the Worksite 1991 - 1993 Update" American Journal of Health Promotion, September/October 1993, 8(1) pp 52-53
- 40 . Fries J., et al "Reducing Health Care Costs by Reducing the Need and Demand For Medical Services", The New England Journal of Medicine, 329(5), July 29, 1993 p 322
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Location of Family Physician Practices in Hamilton-Wentworth (1993)

Boundaries Are Postal Forward Sortation Areas Shaded to Show Percentages of Households Headed by Single Parent Women

APPENDIX 1



GLOSSARY

Accessibility

Refers to the degree to which one is able to secure health care services without physical, language, cultural or economic barriers

Acute Care

Care or treatment for illness or injury requiring concentrated attention by health care workers, usually for a short period of time.

Acuity

The acuteness of an illness.

Allied Health Professional

A person who is not a physician, nurse or pharmacist, and who works in the health field. An allied health professional may, for example, be a dietician or a physiotherapist.

Alternative Therapies / Professionals

Offer therapies, such as reflexology, naturopathy or homeopathy, that are considered outside the practice of Western medicine

Ambulatory Care

Walk-in care not requiring an overnight stay in a hospital

Capitation

A method of payment in which a provider receives a fixed fee per person ("per capita") for a period of time, and the provider agrees to furnish to the persons for whom the capitation payments are received, all the care that may be required (within the contract limitations) without further fee.

Chiropodists

Health professionals who care and treat the human foot in health and disease.

Chiropractic

A system of medicine based on the theory that disease is caused by malfunction of the nerve system, and that normal function of the nerve system can be achieved by manipulation and other treatment of the structures of the body, primarily the spinal column

Community-based care

Health care services provided to individuals and families by non-hospital-based agencies, such as Home Care, Public Health or Community Health Centres.

Community Health Centre (CHC)

A facility which offers a range of coordinated primary health care and related services to one or more priority groups. These services, which are provided by a number of different health professionals, are specifically designed to meet the health needs of the CHC's priority group(s). Health promotion and physician services are essential components of a CHC

The CHC is sponsored and managed by an incorporated, non-profit community board whose members include individuals served by the CHC and others in the community interested in health and social services

Comprehensive Care

In primary care, comprehensive care is the provision of a full spectrum of care including the diagnosis and treatment of disease, health promotion and disease prevention, rehabilitation, counselling and advocacy.

Consumer

Includes members of the general public, consumer groups, community action groups, labour and business, who do not receive any income from the health care system and who are not directly or indirectly involved in the management or delivery of health care services

Continuing Care

Care provided to patients in a manner that responds to their social, recreational, psychological, spiritual and health needs. Patients are assisted to achieve and maintain their maximum potential levels of health and ability. The period of time during which care is required is unpredictable, but usually consists of a matter of months or years.

Continuity of Care

Uninterrupted care of patients by health professionals.

Coordinated Care

Involves a health professional working with other relevant professionals in a planned way to provide the range of services required by a patient.

Demographic Information

Information about a person which includes such items as age, sex, race, income, marital status and education.

Dental Hygienists

Health professionals who clean and examine teeth.

Dentist

A person whose profession is the care of the teeth and surrounding tissues.

Determinants of Health

Refers to factors affecting the health status of individuals, which include biological endowment (such as hereditary disorders); physical environment (such as pollution and adequate housing); social environment (such as family relationships and social supports, employment status and income level); individual behaviour (lifestyle factors such as diet, exercise and smoking); and health care (such as vaccinations, physicians' services).

Dietitians

A health professional who applies the principles of nutrition to the diet.

Discharge

The formal release of a patient from a physician's care or from a hospital.

District

The geographic area contained by the boundaries of each District Health Council.

Effectiveness

Probability of benefit to patients from a specific medical service under average conditions of use.

Efficient

An effect produced with the least expenditure of resources.

Episodic Care Services

Services as walk-in clinics and house-call services which provide medical care outside regular office hours, usually without appointment.

Evidence-based Practice

The use of research and data to influence clinical decisions.

Faculty of Health Sciences

Responsible for major research initiatives and the training of medical students and health professionals from other disciplines.

Family Practice

The specialty of medicine which deals with providing, supervising and coordinating the continuing general medical care of patients of all ages, primarily in family groups. The care provided is primary care.

Fee-for-service

A method of paying physicians and other health care providers in which each service (for example, a doctor's office visit or operation) carries a fee. The physician's income under this system is made up from the fees he/she collects for services.

French Services Designated Area

An area where Francophones form at least 10% of the local population or number at least 5,000 in urban centres.

Fulltime Equivalent - FTE

A measure of staffing resources based on the annual hours of work by a full-time employee.

General Practitioner (GP)

A physician who does not hold specialty qualifications, and who does not restrict his/her practice to any particular field of medicine. General practitioners and family practice specialists are primary care physicians in that they refer patients to other physician specialists.

Geriatrician

A physician specializing in the diagnosis and treatment of problems and diseases of the elderly.

Group Practice

A medical practice where physicians work together, have formal income/expense sharing arrangements and share patient records.

Health

A personal or community state of well-being which encompasses psychological, social, emotional, physical and spiritual elements.

Health Promotion

The process of enabling individuals and communities to increase control over the factors which protect their health, thereby improving their health. The factors which determine the health of individuals and their communities are both individual and societal, including the social, environmental and economic structures of our communities. Individuals and communities need peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity as a prerequisite to health.

Health Service Organization (HSO)

Community, physician and/or hospital-based organizations that provides health care and health-related services to persons who have enrolled voluntarily with the organization. Persons enrolled in an HSO comprise its roster. Once registered with an HSO, patients are expected to receive their primary health-related services through it. In turn, the HSO receives a daily fee or capitation rate to provide health services to registered members. The fee is adjusted according to the age and sex of the patient. HSO's continue to bill fee-for-service for transient patients and for patients who do not wish to join the HSO.

Health Status

The state of health of an individual or population.

Health Status Indicator

A measure that indicates the state of health and wellbeing of an individual or the population (e.g. life expectancy rates).

Home Care

Nursing, professional allied health services and homemaking provided in the patient's home.

Independent Health Facility (IHF)

A place where insured services are provided, but which also charges for items which are not part of those insured services. These are items which support, assist or provide a necessary adjunct to the insured services provided.

Integration

The coordination of a range of services and their delivery. Integration involves a coordination in the structures and practices among the different elements of a system.

Interdisciplinary

A variety of health professionals working together to coordinate their specialized knowledge.

Linkages

The establishment of connections between individuals or between services to strengthen and enhance the delivery of care

Midwife

A health professional with qualifications in obstetric and neonatal (newborn) care who manages maternal and perinatal care in normal pregnancy, labour and childbirth

Morbidity

Illness, injury or other than normal health.

Mortality

A term that applies to death. Usually used in the phrase "mortality rate", which means the number of patients who died.

Naturopaths

A health practitioner who emphasizes the use of natural agents and physical means to treat or prevent disease.

Nurse Practitioner

is a registered nurse with advanced primary health care education and practice. nurse practitioners have advanced knowledge and decision making skills in assessment, diagnosis and health care management related to the provision of health care

Occupational Therapist

A health professional who prescribes activity to promote recovery or rehabilitation

Optometrist

A health professional who examines eyes for defects and prescribes corrective lenses.

Outcome

A term used in evaluating patient care, the health care system and its components.

Pharmacist

A person who is licensed to prepare, dispense and control prescription drugs.

Physiotherapists

A health professional who treats disease by physical and mechanical means (e.g. regulated exercise, water, massage, heat, etc.)

Population Health

Addresses the entire range of individual and collective factors that determine health.

Prevention

Prevention of disease occurs at three levels. These are:

Primary Prevention

Aims to completely avoid the disease.

Secondary Prevention

Aims to detect and cure disease before symptoms occur.

Tertiary Prevention

Aims to minimize the effects of a disease for a patient who already has the disease.

Primary Health Care

Is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost the community and country can afford . . . It forms an integral part of the country's health care system of which it is the nucleus . . . It is the first level of contact of individuals, the family and the community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process . . . Primary health care addresses the main problems in the community, by providing promotive, preventative, curative, supportive and rehabilitative resources accordingly.

Primary Medical Care

Is first contact care which includes the diagnosis, treatment and management of health problems using preventative and promotive strategies at the individual, family and community level

Public Health

Designed to improve the health of the entire community or population group.

Rehabilitation

The provision of time-limited therapeutic services geared towards the restoration (optimization) of health and ability.

Roster

A list of patients who have voluntarily enrolled with a physician practice. (usually in an HSO)

Secondary Care

Care provided by a specialist health care professional, such as a psychiatrist or general surgeon, on referral from a primary care physician

Social Work

Assistance to patients and their families in handling social, environmental and emotional problems (in health care usage, primarily with problems associated with illness or injury).

System

A group of units so combined as to form a whole and to operate in unison. "Health system" implies the collection of parts: sectors, providers, organizations, consumers, which make up the entirety of health/maintenance/protection.

Tertiary Care

Care that requires highly specialized skills, technology and support services. Usually provided in facilities serving a large region or the province as a whole.

Triaging

The sorting of and allocation of treatment for patients

Urgent Care Centre

A freestanding community-based or ambulatory care centre that provides treatment for minor and urgent (non-life threatening) health problems on a non-appointment basis.

World Health Organization (WHO)

The division of the United Nations (UN) which is concerned with health.

PRIMARY HEALTH CARE WORKING GROUP

Consultations / Submissions

Critical Juncture Advisory Meetings and Focus Group Meetings	November 21, 1995: CJAG's: - Sue Vanderbent, Dr. Brenda Copps, Betty Muggah, Dr. Susan Watt, Dr. Marilyn James	
	Wednesday, Jan. 10/96 and Wednesday, Jan. 31/96	Chiefs of Family Medicine meeting - Dr. Scott Wooder, Dr. Ross Allega, Dr. Jennifer Everson and Dr. Carl Moore
	Wednesday, Jan. 17/96:	Meeting with physicians from St. Joseph's Hospital -5 participants
	Thursday, Feb. 1/96:	Meeting with physicians from Hamilton Civic Hospitals -3 participants
	FOCUS GROUPS: November 13, 1995	Dr. Agostino Bellissimo, Ms. Karolina Zanon, Dr. Mitch Baker, Dr. Nick Kates, Ms. Micheline Wylde, Ms. Angela Frisini, Dr. Fran Scott, Dr. Marilyn James, Ms. Barbara Carson Ms. Barbara Cooper, Ms. Mary Ann Thompson
	November 15, 1995:	Dr. Scott Wooder, Dr. Jennifer Jackman, Ms. Martine Auger, Mr. Robert Bisson Ms. Sue Vanderbent, Ms. Karen Anderson, Ms. Janet Baxter, Ms. Marita Zaffiro, Dr. Barbara Leal Ms. Lesia Harasym, Ms. Lily Nestor, Mr. Jerry Smith, Ms. Jean Jones, Ms. Lori McLaughlin
	November 17, 1995:	Dr. Daniel Kollek, Dr. Robert James, Dr. Bruno Vedelago, Ms. Ruth Schofield, Dr. Ian Scott Ms. Vicki Woodcox, Ms. Mary Seigner, Dr. Gina Ogilvie, Dr. Agostino Bellissimo Dr. Chris Patterson, Dr. L. Cellini, Ms. Barbara McKinnon, Mr. Kevin Smith
	January 10, 1996	Dr. Daniel Kollek, Dr. Agostino Bellissimo, Dr. Robert James, Ms. Ruth Schofield, Dr. Barbara Leal Dr. L. Cellini, Ms. Jean Jones, Ms. Barbara Cooper, Ms. Laurie McLaughlin, Mr. Jerry Smith, Jane Underwood, Betty Muggah
	January 12, 1996:	Dr. Jennifer Jackman, Ms. Barb McKinnon, Dr. Nick Kates, Ms. Vicki Woodcox, Ms. Mary Ann Thompson, Ms. Mary Seigner, Ms. Barbara Carson, Ms. Marita Zaffiro, Dr. Kaelyn Kaufman, Marion Branwell, Dr. Scott Wooder, Dr. Lynn Nash, Rita Soluk, Sandy Macpherson

Key Informants	November to December, 1995: Dr. M. Cohen, Dr. Brian Hutchison, Dr. Brenda Copps, Dr. Lynn Na. Dr. Scott Wooder Wednesday, January 3, 1996: Betty Muggah and Jane Worral Thursday, January 11, 1996: Dr. John Nelson
Literature Review	HAPPIN, "Community Health Information Network Development Progress Faxletter", September, 1995 The College of Family Physicians of Canada, et al, <u>The Clinical Practice Management Network, Project Summary</u>, May, 1995 The Health Card Project and the Ministry's Information Systems Group, <u>Evolution To A Smart System For Health</u>, September 5, 1995 Dr. Daniel Kollek, "Trial Of Optical Memory Care As A Patient Carried Medical Record", June, 1991 Pelletier K "A Review and Analysis of the Health and Cost Effective Outcome Studies of Comprehensive Health Promotion and Disease Prevention Programs at the Worksite: 1991 - 1993 Update" <u>American Journal of Health Promotion</u>, September/October, 1993, 8(1) pp 52 - 53 Fries J. et al, "Reducing Health Care Costs by Reducing the Need and Demand For Medical Services", <u>The New England Journal of Medicine</u>, July 29, 1993, 329(5) Butler, Janet, "Prevention May Be More Expensive Than Care", <u>Journal of the Royal Society of Medicine</u>, June, 1993, Vol 86

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Data Sources	COMPAS. <u>Public Opinion Toward Health Care Change in Hamilton-Wentworth</u>, 1996 Ontario Ministry of Health. <u>Ontario Health Survey</u>, 1992. Ontario Ministry of Health. <u>Morbidity and Mortality Statistics Report for Ontario, 1986-1992</u>, 1995 Statistics Canada, <u>Census of Canada</u>, 1991
Other	Presentation to Primary Care Advisory Committee - 15 participants SUBMISSIONS TO THE PRIMARY HEALTH CARE WORKING GROUP Addictions Services Group, (Fraser Stewart, Suzanne Witt, Janet Marlin, Bette Fowler, Samir Iskander, Len Hargot, Valerie Beattie-Dolan, Lorraine Chapman, Rosemary Hilbert, Regan Anderson, Gerarld Smith, Sharon Cavanagh) November 9, 1995 Department of Public Health, Dr. Marilyn James, Medical Officer of Health; November 13, 1995 Paikin Memorial Health Centre, Dr. L. Cellini; November 17, 1995 North Hamilton Community Health Centre, Ms. Mary Siegner and Dr. Gina Ogilvie; November 22, 1995 Dr. Daniel Kollek, November 27, 1995 and February 11, 1996 Hamilton Civic Hospitals, Dr. Scott Wooder, Chief, Department of General Practice, November 29, 1995 The Regional Municipality of Hamilton-Wentworth, Department of Public Health Services, Healthy Growth & Development Branch, Jane Underwood and Vicki Woodcox; December 6, 1995; Jane Underwood, January 15, 1996 Dr. Stephen Lloyd, Chief, Division of Emergency Medicine, Department of Family Medicine, January 17, 1996 Hamilton Civic Hospital's, Department of General Practice, Primary Care Recommendations to the Health Action Task Force, February 1, 1996 Dr. Carl Moore, January 17, 1996 and November 8, 1995.

CONTINUING CARE REPORT OF THE HEALTH ACTION TASK FORCE

HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL

March 29, 1996

ERRATA

Rehabilitation

Table G, p. 15, the time period for the data described is 1994/5.

p. 31, the definition for rehabilitation was taken from the report of the Rehabilitation Strategy Working Groups Regional Roundtables, Nov-Dec 1994.

Table M & N, p. 39 & 40, the population data used is the projected 1994/95 population from the Ministry of Finance.

P. 32, the 43 rehabilitation beds at the Hamilton Civic Hospitals (39 rehab, 4 reactivation) are all at the Henderson site.

Other

p. 72, 8th bullet point should read quality of life of individuals, not quality of five

p. 84, the page references for the recommendations which impact on chronic care beds are p. 60 and p. 88.

Long-Term Care

p. 18 - Table H, the Respite Care is the amount of respite care provided in a person's home.

p. 19, Table I, the title Outreach should read Attendant Outreach and Attendant Care has been included in Supportive Housing. The number of hours listed under Homemakers and Nurses Services are for homemaking services, and the number of visits are for nurses visits.

p. 20, Table J, the number for Homemaking hours should be 665, 139, and the source is the Ministry of Health, Long-Term Care Community Support Services, 1994-95 Summary.

p. 21, the cost of medical supplies, rental of equipment and patient transportation/delivery of dressings is included in nursing services

p. 30, the number for reduced DARTS trips is incorrect and should be deleted.

Chronic Care

p. 16 & 78, the number of permanent admissions to the Continuing Care Centre at Chedoke should be 6, and the number of admissions for respite were 7.

P. 16 & 78, the number of admissions to the two chronic care units for elderly persons should be 22, and not 33.

Palliative Care

p. 90, the figure given for the current cost of the 11 palliative beds at St. Peter's is the operating cost



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